Personality may be psychopathology, and vice versa

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T. Widiger thoroughly discusses the relationship of common personality dimensions to personality disorders and of personality and personality disorders to symptom disorders, also called clinical conditions or Axis I disorders in DSM. In that way, he discusses the relationship between egosyntonic and egodystonic behaviors, feelings, thoughts; between how we *are* in feelings, thoughts and behaviors and what *happens to us*, as for feelings, thoughts and behaviors.

The thesis in this commentary is that personality and psychopathology are sometimes merging into each other, sometimes related although conceptually and functionally different, and sometimes completely unrelated. A conclusion will be that this fact ought to have consequences for diagnostic classification.

Depression is psychopathology. However, not so few individuals are depressed their whole life. They feel insecure, guilt prone, worthless, unhappy, etc. This may be regarded as a personality structure. On the other hand, some have a personality they see as egodystonic: they do not understand themselves, their sudden bursts of anger, insecurity, desperation. This may have to be called psychopathology. Generalized anxiety disorder is for many a chronic feeling of apprehension and fear of what may happen. Schizophrenia has a relatively stable personality forma-

tion. A delusional disorder is often persistent through the whole life. Thus we may say that many Axis I disorders may be stable personality structures.

From another perspective, extreme scores on common personality dimensions, such as neuroticism, are according to any criteria psychopathology, often indistinguishable from clinical entities such as various types of mood and anxiety disorders. An extremely high score on introversion is similar to negative features of schizophrenia, most notably simple schizophrenia. An extremely low score on agreeableness and conscientiousness is certainly a basic core of personality disorders, as Widiger notes.

So what are we left with? The concept of personality has developed within the framework of psychology, especially personality psychology, in contrast to, and sometimes in competition with, clinical psychology. Psychopathology is a concept within psychiatry, although sometimes also accepted within clinical psychology. Personality is usually assessed by means of self-report questionnaires, psychopathology by means of interview, being structured or open-ended clinical. The correlations between common personality dimensions assessed by questionnaire and personality disorders assessed by interview are almost as high as reliability deficiency permits (1). The genetic origin appears to be the same (2,3). What comes out as non-shared environment specific for either questionnaire-assessed personality or interview-assessed psychopathology in twin studies is probably mostly error variance.

Does this mean that personality (extreme) and psychopathology (personality disorders or symptom disorders) always coincide? Probably not. Personality features assessed early in life may develop into risky health behaviors, unfortunate social adaptation, conflicts in relationships and dysfunction in adult age (4,5). This development creates life conditions and events that in turn lead to depression and anxiety, as Widiger stresses. An individual with a tendency to strong introversion may lead a life with few social contacts, producing a feeling of loneliness and subsequent depression. An impulsive person with strong emotional variability may experience frequent breaks and losses in relationships, and consequently anxiety and depression. A number of such sequences are well known to every clinician. At the same time, these personality traits do not need to lead to symptoms. Thus they are not the same as psychopathology. Some will say: yes, but in any case they are personality disorders. However, personality disorders are perhaps not basically different from symptom disorders. They may be due to the same genes (mentioned by Widiger), as seems to be the case for avoidant personality disorders and social phobia (6). They are not either more stable than symptom disorders (7,8).

Where does this lead us? Probably, our current concepts of personality and psychopathology are very rudimentary. We may imagine for instance that what today is diagnosed as major depression consist of a number of disorders of completely different origin. One depressive disorder may simply be a chronic personality entity with a number of lifelong personality traits named depressive and anxiety symptoms today. Another depressive disorder is solely a biological brain event taking place in a person with a completely normal personality without any special triggering environmental event. A third depression, sometimes with additional anxiety, is the normal (common) reaction to extreme life events and conditions. A fourth depression is the consequence of a personality formation that creates obnoxious life events with consequent depression and anxiety reactions. On the other hand, people with extreme scores on personality dimensions may be individuals whose personality features have completely different origins. So, our concepts of personality and psychopathology may be far from what we will find reasonable in the future, when we know more about the causes and the structures behind the concepts.

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